Potential Impact of Two Federal Health Insurance Reform Options on the State of Kansas

Summary. This analysis summarizes the potential impact of two federal health reform options on state budget expenditures in Kansas. The two options are HR 3962, which recently passed the House of Representatives, and S. 1796 as approved by the Senate Finance Committee in September. Both bills have been reviewed by the Congressional Budget Office for their impact on federal spending and coverage at the national level. However, official estimates of state-specific impact are not available from the CBO. KHPA estimates the net impact on state budget expenditures for the two bills is relatively modest despite large shifts in flows of funds within Kansas' health care system and between federal and state taxpayers. Savings of between $25 and $50 million per year, in today's dollars, are expected from the Senate Finance bill. The House bill is also likely to reduce net state expenditures, but savings are lower ($0 - $25 million) and as a result the prediction of savings is more sensitive to our assumptions. Using CBO benchmarks for overall impact, the number of uninsured would be reduced by approximately 190,000 with the SFC bill and 240,000 with the House bill, as compared to the 2008 total of 335,000 uninsured.

Objectives. On November 5th, KHPA received a request from Rep. Lynn Jenkins for an estimate of the impact of HR 3962 on Kansas, and this analysis is provided in response. KHPA does not advocate for or against federal health reforms and does not endorse specific pieces of Federal reform legislation. KHPA's interest in estimating the impact on the state is tied directly to the Agency's role in making sure Kansas is positioned to benefit and succeed should reform pass the Congress. In particular, our efforts are focused on reviewing reform proposals for their impact on Kansas state expenditures, on preserving state flexibility in Medicaid, and on Medicaid operational issues. Some reform bills include options to enhance non-institutional care for those in need of long-term care services, but KHPA has not focused on these proposals and they are not included in this analysis.

Ground rules. This analysis and estimates are based on our current knowledge and interpretation of each bill. This understanding is almost certainly imperfect. All the specific dollar figures in this analysis are in today's (2009) dollars. The idea is to provide a snapshot of what would happen on an annual basis if reform was suddenly and completely implemented right now – an impossible feat, of course, but the exercise helps to focus the analysis on the impacts of the reform bills themselves and not on other changes in the population or health economy that might take place over the next few years. Numbers are characterized in terms of a single out-year, not as multi-year totals. This presents a conservative picture of the impact since state costs tend to be highest in the out-years, while some savings begin to accrue even before the costlier reforms are implemented. At one point in the Congressional debate, the Senate Finance Committee released estimates (produced by the Urban Institute) of the costs of the expansions for each state. As near as we can tell, KHPA's estimates of similar options are close to the Urban Institute's estimates, although the options analyzed below no longer match the reform plan assessed by the Urban Institute. Apart from changes in the reform plans analyzed, the bottom line impact that we project in Kansas is different than the Urban Institute's estimates because of some state-specific nuances that the Senate Finance Committee and the Urban

Institute would not be able to take into account, and because the Urban Institute didn't set out to do a formal budget estimate for each state, and therefore did not include all cost-related provisions in the bill. KHPA's estimates will ultimately prove to be inaccurate, too, but the goal is to be reasonably conservative (which, given the results of the analysis, means that we try not to overstate potential savings) and to acknowledge areas of uncertainty.

Sources for these estimates. Estimates of the size and cost of the Medicaid expansion were provided by our Medicaid actuaries, schrammraleigh Health Strategy, using a comprehensive health insurance modeling tool that they developed. Costs for this external analysis have been absorbed with private grant dollars reserved for the purpose of advancing reform. Other provisions were assessed by KHPA staff using internal data as well as information from federal estimates of the impact of reform. Wherever possible, budgetary, actuarial and econometric assumptions are benchmarked to the best available source, including published research, standard actuarial practices and Congressional Budget Office analyses of federal reform proposals.

Summary of the key impacts of each proposal

 New costs to the State of Kansas. New costs to the state include primarily the impact of an expansion of Medicaid.

- **The rate of enhanced federal matching funds for the Medicaid expansion is the primary determinant of new state costs**. Under the Senate Finance Committee bill (SFC bill), the federal government would pay 95 percent of the cost of an expansion of Medicaid for adults up to 133% of the federal poverty level (FPL) in 2014. The match rate declines to about 92 percent in 2019 and beyond. The state's share would be 8% on a permanent basis. [See section 1601(a)(3) of the SFC bill, which creates new section 1905(y)(1)(B) of the Social Security Act] The Medicaid expansion would bring non-disabled childless adults into Kansas' program for the first time, and expand eligibility for parents from the current level of just under 30% of poverty. Income counting rules are tightened under the Senate bill, so that an eligibility threshold of 133% of the FPL represents a lower level of family income than our current methodology would allow at that percentage. We estimate an equivalent of closer to 120% of FPL using Kansas Medicaid's longstanding rules. We expect the net impact on enrollment in Kansas Medicaid would be about 60,000 additional persons as a result of the SFC bill. While the expansion alone would add about 100,000 new enrollees to the program, other provisions of the bill would shift beneficiaries from public insurance to private insurance. First, health reform would essentially federalize SCHIP (although not completely – see discussion below), so we net out current SCHIP participants. Second, many working poor adults with incomes below 133% of FPL would be covered by their employer as a result of (i) the reforms to the small group insurance market, (ii) the subsidies available to small businesses, (iii) the penalties for larger businesses that do not offer insurance, and (iv) the requirement for individuals to carry insurance. In other words, some

families who would qualify for Medicaid because of their income would likely be covered through an employer instead. That's true now for some families, but the number of employer-covered Medicaid eligibles would grow with reform. Some employer-covered Medicaid eligibles would never even apply for Medicaid, while others would apply, enroll, and then we would turn around and buy them right back into their employer's plan under a new, mandatory premium assistance requirement in the SFC bill. Premium assistance lowers state costs for an estimated 9,000 Medicaid participants under the SFC bill. The expansion under the SFC bill is expected to cost the state $25-30 million per year.

Under the House bill, the long-run match rate for the Medicaid expansion is 91%, leaving 9% of new costs to the State. The House bill also expands coverage to 150% of FPL. Unlike the SFC bill, though, the House bill does not change the definition of income that states must use to calculate eligibility, and this increases the difference in the size of the Medicaid expansion in the two bills. The other major difference is the lack of a mandatory premium assistance program for Medicaid eligibles, which lowers savings attributable to Medicaid participants who obtain insurance through their employer. Overall, net growth in the Medicaid program is expected to be around 100,000 persons under the House bill. As with the SFC bill, this estimate nets out the 40,000 participants currently in the SCHIP program since the SCHIP program sunsets under the House bill. The gross increase in Medicaid alone is about 140,000 persons. The expansion element alone under the House bill, which does not include offsetting savings, is estimated at $50-55 million per year.

- **The Medicaid expansion group would (likely) receive a reduced package of Medicaid services.** Medicaid-only benefits like long term care, home health, and targeted case management would be excluded. States currently have the flexibility to offer reduced benefits to adult populations like those covered through the SFC bill's expansion using Deficit Reduction Act (or "DRA") minimum benefit flexibility. The SFC bill refers to these as "1937" benefits in reference to the section of the Social Security Act where DRA flexibility now resides. While the House retains DRA/1937 benefit flexibility to states, the SFC bill level-sets those benefits for the Medicaid expansion at the DRA minimum, which is equivalent to the predominant Blue Cross plan in a state, or benefits provided through the state employee plan. Our analysis assumes that new Medicaid recipients under both the SFC and House bills would receive reduced 1937/DRA benefits, although under the House Bill, the level of benefits would need to be set by the Legislature, and could be more expansive. Section 1937 DRA benefits are expected to include full prescription drug coverage and mental health benefits, but would not include such services as home health benefits or targeted case management services.

- **Health reforms, including the individual mandate, would bring currently eligible persons into the program.** There would be a woodwork effect that bringing thousands of non-participants into the Medicaid program. We might also expect Medicaid participation rates to grow with the realization by providers that everyone below a certain level of poverty is Medicaid-eligible. That simplicity will make outreach and enrollment far more effective, expanding opportunities for provider-facilitated enrollment. It is also possible that provider expectations and choices in debt collection and the provision of uncompensated care to low-income families could change given the universal availability of either Medicaid benefits or substantial subsidies for private coverage. Although this is purely speculative, such a change in provider expectations could also serve to push up rates of participation, apart from the new statutory requirements for individuals to carry insurance for themselves and their children.

- **There is a wildcard provision in the SFC bill expanding the Medicaid individual entitlement.** A provision to redefine the meaning of "medical assistance," which has referred to payments since Medicaid was written into the Social Security Act 44 years ago, would appear to add a significant new individual entitlement to the prompt receipt of services. There are apparently long-standing legal disputes over the question of whether states have an obligation to provide timely services to recipients, and this provision would answer that question with a new guaranty for beneficiaries. Many states are likely to raise significant concerns about this provision, especially given the historical challenges states have faced in procuring timely and adequate services. This provision carries a cost to Kansas, but we do not know how to quantify that cost. This provision is not included in the House bill.

- **Uncertainty over the size and cost of the Medicaid expansion**. Per-person costs under the expansion are tied directly to current spending levels for comparable populations in the Kansas Medicaid program. These costs are also in line with separate actuarial estimates for the same population and the same DRA/1937 benefit package proposed for the premium assistance program developed by KHPA in 2007. In addition, these costs are very close to premiums in effect under the recent expansion of public benefits in Massachusetts. Cost estimates assume consistency in both benefits and provider rates. Many question whether current Medicaid rates would be sufficient to purchase access for the expansion population given the limited number of providers available at current rates. This concern may lead to future policy choices for Congress and the Kansas Legislature over provider rates and could also lead to considerations of changes in health care workforce training programs and provider scope of practice laws, but those future choices cannot be built into this estimate. Given those limitations, we

have a relatively high degree of confidence in per-capita costs under the expansions in comparison to existing public and private costs, and it is this difference in costs which drives this estimate of impact on the state.

We have less confidence in the projected size of the expansions. Expansions could be sensitive to error in assumptions about the Kansas population derived from survey data (i.e., the Current Population Survey), errors in assumptions about the growth in employer-based coverage under reforms, and errors in assumptions about individual decisions to enroll in Medicaid. This estimate of cost is modestly sensitive to the size of the expansion, and to the number of existing Medicaid eligibles – mostly children -- who newly enroll because of the reforms (i.e., woodwork effects). However, the state would bear just 8-9% of the costs of newly-eligible enrollees under the expansion, and 40% of the cost of less costly children who are already eligible. If our estimates were off by as much as 30,000 adults and kids newly enrolling in Medicaid, for example, the total cost of reform could be another $10-15 million per year higher than we have estimated.

- **Implementing and operating the Medicaid expansion would add administrative costs that could reach $3-6 million annually.** Implementation costs would include systems changes, contract amendments and new state personnel to address the increase in Medicaid's size and volume of claims and enrollment activity. Neither the SFC bill nor the new House bill provides added administrative dollars to states to help with reform. Existing sources of federal matching funds for administration would continue to apply.

 New savings to the state. There are several sources of savings to the state under both the House and SFC bills, some of which would depend upon future policy choices by the state.

- **The SCHIP program would be essentially federalized in 2014, and this will save Kansas about $18 million per year**. Under the SFC bill SCHIP is maintained until 2019 when it sunsets, but the match rate is increased by 23 percentage points beginning in 2014 (to 95% for Kansas). The future of SCHIP is not clear, and the manner in which states are to operate the program during the 2014-2019 period is unclear. A program designed for the uninsured may be difficult to define and administer in the midst of a reformed market with potentially universal access to other sources of affordable coverage. It is not clear which children should be enrolled and which should not. In the meantime, though, the SFC Bill preserves the program's current spending cap and nearly federalizes the programs cost at a 95% match rate. Because SCHIP is essentially federalized, then sunsets, we count the 40,000 kids enrolled as a reduction in the size of Medicaid in the SFC estimate of a net growth of 60,000.

  Under the House bill, SCHIP sunsets in calendar year 2014, when children above 150% of poverty are transitioned into other sources of private coverage with their

parents. Many would be eligible for tax subsidies to purchase insurance through a health insurance exchange.

- **Kansas' non-disabled medically needy population would be significantly reduced, saving the state perhaps $25 million per year**. Although Kansas would need to maintain this program under a Maintenance of Effort requirement, the piece of Kansas Medicaid that provides coverage to low-income persons with high health costs will be much smaller after reform, since few low-income persons will have the chance to incur high out-of-pocket health costs after the coverage expansions take place. Others would enroll in the new expansion program for Medicaid as soon as they arrive at the hospital, and before incurring significant out-of-pocket costs. KHPA would maintain this category of eligibility, but many would no longer qualify. Kansas will likely see a large shift from coverage of medically needy individuals to the new, higher-match federal Medicaid expansion, or into the exchange. SFC and House bill language is silent on the issue of the medically needy coverage, which some states do not offer. But the goals of health reform would seem to guarantee that Kansas will no longer have a significant number of non-aged, non-disabled individuals who are required to "spend down" their income on health services in order to meet eligibility criteria. Given the goals of reform, it may well become federal or state policy to prohibit the requirement that individuals impoverish themselves on medical care spending in order to become eligible for Medicaid. There is some possibility that disabled medically needy individuals would also benefit from the expansion of coverage under the House bill, but we do not take those potential savings into account.

- **Kansas will need to make choices about whether to maintain State-only programs like MediKan at current levels: savings could vary from $0 to more than $10 million per year.** Health reform would bring several hundred million dollars per year in federal funding into the state through Medicaid and individual subsidies. As a whole, the state would also generate its share of the sources for this new federal spending (e.g., taxes on high-end insurance policies, taxes on high-income earners, reductions in Medicare payments, etc.). On average, though, public spending on health insurance would grow. Based on KHPA's analysis, total spending at the state level for health care appears to fall under the two options analyzed. But behind that overall assessment of cost, there are large shifts in payments that affect taxpayers, the uninsured, businesses of different sizes, providers of different types, and insurers. It may take some time to sort through these flows of funds to understand the impact on specific types of state-subsidized providers, for example, and to assess remaining funding needs for those who currently serve significant a number of the uninsured. With so much in new funding for the uninsured, Kansas will be faced with new choices about whether to maintain or redirect state dollars currently allocated to direct health care subsidies, including Medicaid programs for underserved populations (e.g.,

disproportionate share hospital payments and cost-based reimbursement to health and mental health clinics and critical access hospitals), the state-only MediKan partial insurance program, and state-only appropriations to health care and mental health clinics. It would be premature to recommend for or against such cuts at this point, but those questions will need to be addressed if reform passes.

- **The state would share in federal Medicaid savings provisions, yielding a total of $14-16 million dollars per year in savings**.
    - The SFC and House bills both increase Medicaid drug rebates from pharmaceutical manufacturers that would reduce Kansas' share of prescription drug costs. This would likely save Kansas $6-8 million dollars per year beginning in 2010.
    - Both bills also reduce disproportionate share hospital payments in Medicaid. Kansas would share in these reductions, which represent a diversion in payments for uncompensated care from supplemental hospital payments to coverage. The formulaic reductions are unclear and depend upon future choices by the federal government, but we estimate savings to the state of about about $8 million per year.
    - In the SFC bill there is a temporary increase in the federal match rate for all Medicaid costs of .15 percentage points over a five year period (2014-2019) that would save the state about $3-4 million per year. These savings are not included in our long-run estimates, but would total $15-20 million over the five year period.

 Net impact on the state budget.

- **We estimate the health care-related provisions in the SFC Bill would yield modest savings for the State budget in the long run.** We estimate that the SFC bill would reduce net state expenditures by at least $25-50 million per year under a fairly wide range of assumptions. This estimate compares current annual expenditures to a single outyear's expense under reform, and is expressed in current dollars. In reality, we expect there will be growth in medical costs and inflation that would increase both spending and avoided spending (i.e., savings) under reform. As a point of comparison, $25-50 million represents 4-9% of current state spending on KHPA's regular medical expenditures. If several of our assumptions were overly optimistic, i.e., the expansion was much larger, significantly more expensive per person, and the savings from the medically needy program much smaller, savings would still be positive, e.g., $10-20 million per year (2-3% of KHPA's current caseload costs).

- **We estimate probable savings under the House bill, but the level of savings would be lower than with the SFC bill**. Expected savings are lower due to the larger Medicaid expansion, the 1% reduction in the long-run match rate for the Medicaid expansion, and the lower expected savings from premium assistance employer buy-ins for Medicaid recipients. The state fiscal impact of the House bill is expected to be between $0 and savings of $25 million per year. Conversely, the higher percentage of the uninsured who would be covered under the House bill increases the possibility of reductions in state-only health care spending. If several of our key assumptions are overly optimistic, there is a possibility the bill could cost the state as much as $5-15 million per year (1-2% of current medical caseload costs).